EXHIBIT 7

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

IN RE: DA VINCI SURGICAL ROBOT ANTITRUST LITIGATION	**Lead Case No. 3:21-cv-03825-VC**
THIS DOCUMENT RELATES TO: **All Actions**	

EXPERT REPORT OF DR. EUGENE RUBACH

I. QUALIFICATIONS

1. I am a board-certified general surgeon currently practicing in the state of New York. I have been in practice for more than 17 years and specialize in minimally invasive general surgery. I graduated from Rutgers University with a Bachelor of Arts degree in 1995, and from New Jersey Medical School in 1999 with an MD degree.

2. In June of 2004, I completed a general surgery residency program, where I learned both open and laparoscopic surgical techniques. In 2005, I completed a fellowship in minimally invasive general surgery, where I received formal specialized training in advanced laparoscopic and robotic surgery. Surgeons commonly refer to these two techniques together as "minimally invasive surgery." I have been in active surgical practice without interruption since completion of

this fellowship. The majority of the operations (more than 80%) I have performed in my career were done using minimally invasive techniques (both laparoscopic and robotic).

3. During my 17-plus years of performing minimally invasive surgery, I have gained extensive experience with all of the widely-used Intuitive Surgical da Vinci surgical robots. I have personally performed hundreds of procedures using the da Vinci S, Si, and Xi models. While performing these operations, I used a variety of "wristed" (or articulating) robotic EndoWrist instruments. I also have extensive experience performing (a) "conventional" laparoscopic surgery using straight (non-articulating) surgical instruments, as well as (b) "single-site" laparoscopic surgery utilizing articulating (wristed) non-robotic instruments. Finally, I have extensive experience using articulating surgical video cameras (laparoscopes).

4. I have co-authored several clinical articles in the field of minimally invasive surgery. Of particular relevance in the context of this litigation, I co-authored an article describing a standardized approach to robotic colon resection, published 16 years ago (J Laparoendosc Adv Surg Tech A. 2006 Dec;16(6):551-6. doi: 10.1089/lap.2006.16.551). This article, one of the first to delve into this area, describes the performance of a robotic colectomy using the da Vinci S robot and EndoWrist instruments. I also participated in the development and publication of a consensus statement on laparo-endoscopic single-site cholecystectomy (Surg Endosc. 2012 Oct;26(10):2711-6. doi: 10.1007/s00464-012-2478-y. Epub 2012 Aug 31). This latter journal article describes the use of articulating (wristed) surgical instruments in performance of conventional laparoscopic (non-robotic) operations. Finally, I participated in the research and publication of one of the earliest institution-wide comparisons between laparoscopic and robotic colo-rectal surgery (Surg Endosc. 2012 Apr;26(4):956-63. doi: 10.1007/s00464-011-1977-6. Epub 2011 Nov 2). A complete list of my publications from the last 10 years is included in Appendix A.

5. In addition to my clinical and research responsibilities, I serve as a Vice-Chairman of Surgery at St. Francis Hospital in Roslyn, New York, and as a Cancer Liaison Physician for the American College of Surgeons Commission on Cancer. I also participate in yearly volunteer surgical missions in Africa.

II. ENGAGEMENT

6. I am submitting this expert report at the request of counsel for the named plaintiffs, Larkin Community Hospital, Franciscan Alliance, Inc., and King County Public Hospital District No. 1 (DBA Valley Medical Center) (collectively, "the Hospital Plaintiffs"), in *In Re: Da Vinci Surgical Robot Antitrust Litigation*. Counsel for the Hospital Plaintiffs have asked me to describe my experience with minimally invasive surgery in general and specifically in connection with the da Vinci robot and EndoWrists. Specifically, I have been asked by counsel to opine on (a) the availability of surgical robots comparable to the da Vinci, and how that impacts surgeons and hospitals; (b) the consequences of instrument "failure" during minimally invasive surgery from the standpoint of patient safety; and (c) whether the EndoWrist use limits are reasonable and/or useful.

7. In preparing this report, I relied on my extensive educational and clinical experience with robotic and laparoscopic surgery. In addition. I reviewed (a) deposition transcripts, including those of Drs. John Bomalaski, Gene Dickens, Greta Bernier, Ricardo Estape, Michael Burke, John Francis, and Myriam Curet, Intuitive's Chief Medical Officer, (b) the expert report submitted by Dr. Bomalaski in the *Rebotix v. Intuitive* litigation, (c) various documents produced in discovery in this litigation, and (d) the Hospital Plaintiffs' complaint. I am working through Gerson Lehrman Group, Inc., which is being compensated for my time at $1,075 per hour. My compensation is not contingent on the outcome of this litigation or the content of my opinions.

8. My publications from the last 10 years are listed on my CV, which is attached as Appendix A. The documents and other materials I considered in forming my opinions are contained in Appendix B. Within the past four years, I have not provided deposition testimony as an expert or testified in court as an expert.

III. SUMMARY OF OPINIONS

9. U.S. hospitals that do not have a da Vinci robot find themselves at a great disadvantage in: (a) attracting well qualified surgeons who practice minimally invasive surgery, and (b) trying to appeal to patients seeking minimally invasive surgical treatments.

10. It has always been my understanding that hospitals that acquire a da Vinci robot are required to continually purchase new EndoWrist instruments to keep their robots in use.

11. Surgeons use surgical instruments in ways that safeguard against patient harm, even in the face of instrument failure. Surgical instrument failure during surgery generally leads to replacement of the failed instrument with a working instrument, and then the continuation of the operation as planned.

12. Intuitive disables EndoWrist instruments based on criteria, which, in my opinion as a surgeon, are arbitrary and do not reflect whether an EndoWrist is suitable for clinical use.

IV. OVERVIEW OF SURGEONS' USE OF ENDOWRISTS AND OTHER MINIMALLY INVASIVE INSTRUMENTS

13. Robotic and laparoscopic surgery are two types of minimally invasive surgery commonly performed in hospitals and ambulatory surgery centers.

14. If surgical instruments are directly moved by the surgeon's hands, it is usually referred to as "laparoscopic surgery." If the instruments are moved by a robot, which in turn is controlled by a surgeon, it is termed "robotic surgery."

15. Both approaches require the use of surgical instruments by well-trained surgeons.

16. In performance of any minimally invasive surgeries, small incisions are made in the skin through which long instruments and a video camera (commonly called a laparoscope) are inserted into the body. The instruments are operated from outside the patient while their tips perform surgical maneuvers (such as cutting, retracting, sewing, etc.) inside the patient.

17. Laparoscopic devices and instruments are "generic" in that many companies produce similar products within well-regulated markets for medical devices. As a result, numerous companies manufacture and reprocess the same or functionally similar instruments to compete for hospitals' business.

18. Minimally invasive robotic surgery is dominated by a single manufacturer: Intuitive. Its da Vinci robots only use instruments that are manufactured by Intuitive itself. All other minimally invasive instruments are incompatible with Intuitive's robots. Furthermore, Intuitive renders its instruments useless after a defined number of activations. Absent third-party repair, such instruments cannot be reused or refurbished and must be discarded. Hospitals then need to purchase new instruments to continue using the robot.

19. A da Vinci surgical robot is not really a robot as that term is commonly used, as it does not independently operate on patients. Instead, it is a remote tele-manipulator that transmits surgeon movements into instrument movements inside the patient. The da Vinci is comprised of three parts: 1) a surgeon console (with its controls), 2) patient side arms (or cart, to which surgical

instruments can be attached), and 3) a vision cart. The vision cart feeds the picture from inside the body onto a 3D screen. A surgeon sits at a console with her hands and feet on the controls and looks into that 3D screen. The controls are linked to the patient-side cart, which is attached to the patient, and has up to four arms that hold instruments. As the surgeon conducts the operation by operating da Vinci controls, the arms at the patient's side replicate the surgeon's motions. These arms are holding various surgical instruments (EndoWrists) required to conduct the procedure.

20. Minimally invasive surgical instruments can either be rigid, where the tip of the instrument is rigidly attached to the instrument shaft, or wristed (articulating), where the working tip can bend freely in relation to the shaft. In the first case, the instrument movements are restricted akin to a wrist in a cast (limited to up, down, left, right, in, out and rotational movements). In contrast, articulating surgical instruments move like a normal wrist, such that they can bend in many directions in addition to moving up, down, left, right, etc. These latter articulating instruments – when manufactured by Intuitive – are trademarked as "EndoWrists." When articulating (or rigid) instruments are not moved in surgery by a robot and are manufactured by companies other than Intuitive, they generally are not referred to by specific trademarked names.

21. Only EndoWrists can be used with da Vinci robots. Furthermore, no other company has – so far – been able to market a competitive minimally invasive surgical robot. Thus, Intuitive, with its da Vinci robot, is currently the dominant force in minimally invasive robotic surgery in the U.S. As a result, hospitals using da Vincis have no choice but to continually purchase EndoWrists from Intuitive. This is the only way to keep da Vincis in use.

22. In 2003, it is my understanding that Intuitive acquired Computer Motion, the manufacturer of a competing surgical robot called "Zeus." Soon after, the Zeus robot was phased out by Intuitive in favor of the da Vinci, which remains the dominant minimally invasive surgical

robot to this day. While the Zeus robot was conceptually similar to the da Vinci, Zeus instruments – in contrast to EndoWrists – were also able to provide haptic feedback. In simple words, a surgeon operating a Zeus robot was able to feel the tissue with his/her robotic instruments – similar to how humans feel texture with their fingertips, or how surgeons holding conventional laparoscopic instruments can feel the density of organs on which they are working. Such haptic feedback ability does not exist with the da Vinci and its EndoWrists, which lack the ability to transmit tactile sensations back to the operating surgeon. This has been a disappointing shortcoming of the da Vinci robot throughout its existence, and has been a source of widespread criticism by surgeons who use the da Vinci.

23. As a consequence of Intuitive's domination of the minimally invasive robotic surgery market, any hospital that wants to attract a modern minimally invasive surgeon to its staff must have at least one, and usually more than one, da Vinci robot. Furthermore, a da Vinci robot (with all of its EndoWrists) is necessary to appeal to patients, who are more than ever interested in modern minimally invasive robotic surgical treatments. As a result, hospitals that do not have a da Vinci robot in the U.S. find themselves at a great disadvantage in attracting well qualified surgeons that perform minimally invasive surgery, as well as educated patients seeking minimally invasive surgery, as they have neither the dominant minimally invasive surgical robot, nor the well qualified surgical staff that comes with it.

24. In addition to attracting well qualified surgeons and educated patients, having a da Vinci robot also creates a "halo effect" for other hospital services, and can improve community and referring physician perceptions. And in addition to attracting those patients who will be treated with robotic surgery, such "halo effect" can also attract patients (and revenue) for other procedures.

25. Hospitals' need for minimally invasive surgical robots requires significant initial and continued expenditures. They first must buy or lease the da Vinci robot. To keep their robot operational, they then have to continuously purchase and re-purchase EndoWrist instruments.

V. FAILURE OF ENDOWRISTS AND OTHER MINIMALLY INVASIVE INSTRUMENTS DURING SURGERY

26. All surgical instruments should be made to work reliably and precisely. Like any electric or mechanical device, however, they can fail. Although it may seem to someone without first-hand experience performing surgery that a surgical instrument "failure" would be a catastrophic event, it almost never is. When scissors become dull and stop cutting, a surgeon simply replaces them with a new one and continues the surgery. When a spring in a needle holder breaks, that instrument is removed and a new one is opened onto a surgical field. While the operations then continue as planned, the malfunctioned instruments are sent to be evaluated, after which they are either discarded or repaired and returned into normal use. I have personally encountered several EndoWrist failures during surgery, none of which put the patient's safety at any risk. On two occasions, the scissors became dull and stopped cutting tissue during hernia operations; those scissors were simply replaced and I completed the procedures. On another occasion, a cable inside the double-fenestrated grasper snapped, rendering it useless. To compensate, I regrasped the tissue with another instrument until a new grasper could be brought into the operating field, which allowed me to continue and complete the procedure.

27. Furthermore, surgeons use surgical instruments in ways such that their failure would result in minimal or no harm to the patient. For example, if an electrical surgical stapler jams during its use or runs out of battery power, it comes with a mechanical key to safely open and release it. Or if a vessel sealing device suddenly malfunctions during an operation, a surgeon

should have the skills and knowledge to use other techniques to control the bleeding, such as sutures or clips. None of the EndoWrist failures I encountered during surgery resulted in harm to the patient. The "failed" instrument simply was swapped out for a working one and the surgery carried on as planned.

VI. ENDOWRIST USE LIMITS ARE ARBITRARY

28. Some instruments, such as clip appliers, are marketed for a single-use. These are either discarded after one use or sent to one of many companies that reprocess such instruments for possible further use. There, these instruments are assessed to determine if they remain safe and effective for their intended clinical use. If confirmed to be functional, they are cleaned, re-sterilized, and returned back into circulation – often at a significant discount to their original price.

29. It is commonplace for both single-use and multiple-use surgical instruments to be repaired or reprocessed. Once assessed to be safe and functional, they are returned into use in operating rooms. I routinely use such repaired and reprocessed instruments and find them safe and effective.

30. In contrast to the processes described above, all surgical instruments that carry the EndoWrist trademark have a pre-determined number of uses set by Intuitive, frequently 10. This is the number of ***patients*** on which any given EndoWrist can be used. It is not the number of hours the instrument is used, as using it for 10 seconds during a simple procedure or using it for 10 hours continuously during a complicated cancer resection will both count as one use. It is also not the number of times it is inserted or removed from a patient's body during a particular operation, as one insertion or 100 insertions during the same operation would both count as the same one use. It is also not the number of times each instrument is re-sterilized, as re-sterilizing the instrument

20 times without ever attaching it to the robot will not count as a use at all. After being used on 10 patients, Intuitive's use counter renders each EndoWrist nonfunctional, regardless of whether it is operational or not. This is similar to rendering a car inoperable based on the number of times its driver's door was opened, as opposed to the car's age, or mileage, or intensity of its use, or the actual ability of the car to continue functioning as designed, notwithstanding its prior use.

31. The arbitrariness of Intuitive's use counter is highlighted by the fact that sometimes EndoWrist instruments fail before their 10th surgery, as one might expect, especially when the instrument was used during long and/or intense prior operations. At other times, the use counter renders the EndoWrist instrument unusable, even though it was lightly utilized in 10 previous patients and would likely last much longer even without any servicing. Regardless, after 10 uses, an error message will flash on the screen, and the robot will fail to recognize the EndoWrist instrument. Thus, such instrument will no longer function when attached to a robotic arm and must be discarded, notwithstanding its ability to continue performing its intended clinical duties. I am unaware of any other multi-use surgical instruments, aside from EndoWrists, that have a use limit as low as 10.

32. One more illustration of the arbitrariness of Intuitive's use counter/limits would be when the "wrong" instrument is attached to the robot during surgery, which would count as a use even though the instrument was not used at all. To avoid a situation where an instrument is accidentally attached and thus "used," and the waste to the hospital that comes with it, I insist that no robotic instruments are opened onto the surgical field without me specifically asking for them. I insist on this "JIT" ("just in time") rule - the instrument is in the room, available for use but not opened onto the field unless needed - to save costs and avoid excess instrument use.

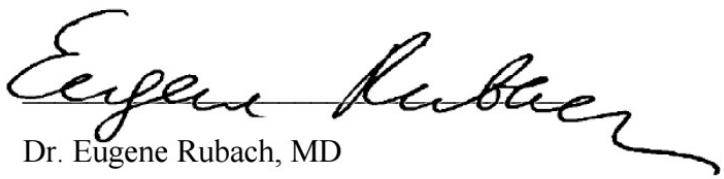
33. To summarize, Intuitive requires that only EndoWrist instruments be used with da Vinci robots and it intentionally disables these EndoWrist instruments based on criteria which, in my opinion as a surgeon, are arbitrary and do not reflect whether the EndoWrist is suitable for clinical use.

34. It is also my understanding that Intuitive prohibits third-party repair of EndoWrist instruments, and using them beyond their preprogrammed attachment or use limits, even though (a) the use of repaired surgical instruments is standard, and (b) such instruments are in my experience safe and effective.

35. From my perspective as a surgeon, there is no reason to treat EndoWrist instruments differently than their laparoscopic counterparts, which are used until they either cease to function effectively or show signs of likely imminent failure. At that point, they can be evaluated by a hospital, a surgeon and/or a surgical device repair company and, if appropriate, tuned up and returned to use. The use limits and repair restrictions that Intuitive places on EndoWrists are arbitrary from a surgical perspective, and do not appear to advance any medical objectives.

36. While I do not know whether the use counter solves any safety or quality issues, that is what Intuitive sales representatives say when asked. However, I am unaware of any safety or quality issues that the use limits solve that could not be solved with less restrictive measures, such as the existing practice of hospital staff evaluating repaired laparoscopic instruments.

I declare under penalty of perjury that the foregoing is true and correct. Executed this 1st day of December 2022, at Roslyn, NY.



Dr. Eugene Rubach, MD

APPENDIX A

EUGENE RUBACH, MD, FACS

2200 NORTHERN BLVD, SUITE 125 • EAST HILLS, NY • 11548

PHONE (516) 627-5262 • FAX (516) 627-0641 • ERUBACH@GMAIL.COM

PROFESSIONAL EXPERIENCE

2020-current St. Francis Hospital Roslyn, NY
Vice-Chairman, Department of Surgery

2008-current Catholic Health Services of Long Island Roslyn, NY
Attending Surgeon, Department of Surgery

- Perform general surgical procedures with emphasis on minimally invasive oncologic surgeries, gastrointestinal tract procedures and hernia operations

2005-2008 North Shore/Long Island Jewish Health System Manhasset, NY
Attending Surgeon, Department of Surgery

- Performed general surgical procedures with emphasis on laparoscopic operations
- Participated in the development of robotic general surgery program

ACADEMIC APPOINTMENTS

2009-current Hofstra University School of Medicine Hempstead, NY
Clinical Assistant Professor of Surgery

2005-2009 Albert Einstein College of Medicine New York, NY
Assistant Professor of Surgery

2003-2004 Albany Medical Center, Department of Surgery Albany, NY
Instructor of Surgery

EDUCATION

2004-2005 North Shore/Long Island Jewish Health System Manhasset, NY
Fellow in Minimally Invasive, Gastrointestinal and Robotic Surgery

1999-2004 Albany Medical Center Albany, NY
Resident and Chief Resident

- Division of General Surgery

1995-1999 University Of Medicine and Dentistry of NJ Newark, NJ
Doctor of Medicine

1993-1995 Rutgers University Newark, NJ
Bachelor of Arts magna cum laude

- Major: Biology

BOARD CERTIFICATION

American Board of Surgery Philadelphia, PA

- Certified 2005; recertified 2015
- Fellow of the American College of Surgeons (FACS) since October 2007

MEDICAL LICENSURE

New York State Medical License # 231307

PROFESSIONAL ASSOCIATIONS

2001-current	American College of Surgeons (ACS)	Chicago, IL
2002-current	New York Chapter of the ACS	Albany, NY
2002-current	Society of American Gastrointestinal Endoscopic Surgeons (SAGES)	Los Angeles, CA
2004-current	Society of Laparoendoscopic Surgeons (SLS)	Miami, FL
2012-current	Society of Surgical Oncology (SSO)	Chicago, IL

AWARDS RECEIVED

2008-2018	Patient's Choice Award	Vitals.com
2009-2018	Compassionate Doctor Recognition	Vitals.com
2014-2018	On-Time Doctor Award	Vitals.com
2010	SLS Honorable Mention Award *For General Surgery Video Presentation*	New York, NY
2002	Alpha Omega Alpha (ΑΩΑ) *Honorary Medical Society member*	Albany, NY
2004	SLS Outstanding Laparoendoscopic Resident Surgeon *For achievements in operative laparoscopy*	Miami, FL
2003 & 2004	Morris Alpert Resident Research Awards *For the best resident research projects*	Albany, NY
2002	Best Surgical Grand Rounds Award *For the best General Surgery teaching conference of the year*	Albany, NY
1995	Lezburg Scholarship Award *For outstanding achievements in medical school*	New York City, NY

PUBLICATIONS

V Kamath, AL Rios, N Mishra, S Sathyanarayana, K Krishnasastry , **E Rubach**
Laparoscopic Left Gastric Artery Aneurysm Resection
International Journal of Angiology. 2016 25:5 e115-117

JM. Marks, M Phillips, R Tacchino, K Roberts, R Onders, G DeNoto, G Gecelter, **E Rubach**, H Rivas, A Islam, MD, Nathaniel Soper, et al.
Single-Incision Laparoscopic Cholecystectomy Is Associated with Improved Cosmesis Scoring at the Cost of Significantly Higher Hernia Rates: 1-Year Results of a Prospective Randomized, Multicenter, Single-Blinded Trial of Traditional Multiport Laparoscopic Cholecystectomy vs Single-Incision Laparoscopic Cholecystectomy
Journal of the American College of Surgeons 2013 216:6 1037-1047

G Deutsch, S Sathyanarayana, J Nicastro, E Molmenti, G Coppa, **E Rubach**, B Friedman
Dual Pathology in a Patient with Right Lower Quadrant Pain
International Journal of Angiology. 2012 21:3 155-158

M Phillips, J Marks, K Roberts, R Tacchino, R Onders, G DeNoto, H Rivas, A Islam, N Soper, G Gecelter, **E Rubach**, P Paraskeva, S Shah.
Intermediate results of a prospective randomized controlled trial of traditional 4-port vs. single-incision laparoscopic cholecystectomy
Surgical Endoscopy. 2012 26:5 1296-1303

S Ross, A Rosemurgy, M Albrink, E Choung, G Dapri, S Gallagher, J Hernandez, S Horgan, W Kelley, M Kia, J Marks, J Martinez, Y Mintz, D Oleynikov, A Pryor, D Rattner, H Rivas, K Ruberts, **E Rubach**, et al.
Consensus statement of the consortium for LESS cholecystectomy
Surgical Endoscopy. 2012 26:10 2711-2716

G Deutsch, S Sathyanarayana, V Gunabushanam, N Mishra, **E Rubach**, H Zemon, J Klein, G DeNoto
Robotic vs. laparoscopic colorectal surgery: an institutional experience
Surgical Endoscopy. 2012 26:4 956-963

A Joshi, J Spivak, **E Rubach,** G Goldberg, G DeNoto
Concurrent robotic trans-abdominal pre-peritoneal (TAP) herniorrhaphy during robotic-assisted radical prostatectomy
International J of Medical Robotics and Computer Assisted Surgery. 2010 6:3 311-4

E Agaba, R Zaidi, P Ramzy, M Aftab, **E Rubach**, G Gecelter et al
Laparoscopic Hartmann's procedure: a viable option for treatment of acutely perforated diverticultis
Surgical Endoscopy. 2009 23:7 1483-1486

H Aror, J Romero, **E Rubach**, R Silverman
Spontaneous intrahepatic hemorrhage: A case report
Journal of Emergency Medicine. 2008 Aug (online)

G DeNoto, **E Rubach**, TS Ravikumar
A Standardized Technique for Robotically Performed Sigmoid Colectomy.
Journal of Laparoendoscopic and Advanced Surgical Techniques. 2006 Dec 16(6) 551-6

A Holodny, V Sharma, **E Rubach**
Long-Standing Unilateral Jumped Facets At C3-4 With No Apparent History Of Antecedent Trauma.
Emergency Radiology. 2003 9:6 329-333

E. Rubach. Examination of mouse macrophages for the presence of defensins.
Student Research Abstracts. Newark, NJ. 1996:62

SCIENTIFIC PRESENTATIONS

E Rubach, G DeNoto Robotic Inguinal Hernia Repair during Robotic Prostatectomy
2014 American Urologic Association NY Meeting Stockholm, Sweden

M Phillips, J Marks, R Tacchino, K Roberts, G DeNoto, R Onders, E Rubach, et al. Surgical Outcomes Identified in a Multicenter

Prospective Randomized Controlled Trial of Standard Four Port Versus Single Incision Laparoscopic Cholecystectomy
American College of Surgeons 2011 Scientific Session San Francisco, CA

M Phillips, J Marks, R Tacchino, K Roberts, G DeNoto, R Onders, **E Rubach**, et al. Univariate Analysis of Pain, Quality of Life, and Cosmesis Scores For Single-Incision and Standard Laparoscopic Cholecystectomy in a Prospective Multicenter Randomized Trial
American College of Surgeons 2011 Scientific Session San Francisco, CA

E Rubach, J McDevitt, G Gecelter. Single incision laparoscopic surgery: experience with 151 consecutive cases.
2011 New York Surgical Society Meeting New York City, NY

M Phillips, J Marks, R Tacchino, K Roberts, G DeNoto, G Gecelter, **E Rubach**, et al. Prospective randomized controlled trial of traditional four port laparoscopic cholecystec-tomy versus single incision laparoscopic cholecystectomy
SAGES 2011 Scientific Session San Antonio, TX

E Rubach, G Gecelter. Single-incision Laparoscopic Right Hemicolectomy: A Reproducible Operation That Follows Strict Oncologic Principles
Society of Laparoendoscopic Surgeons 2010 Meeting New York, NY

J Taylor, N Hubbard, N Mishra, M Schwartz, M Ostrowitz, D Eschete, **E Rubach**, L Richstone, et al. The current status of laparo-endoscopic single-site surgery (LESS) across surgical disciplines, a single institution's experience.
SAGES 2010 Scientific Session National Harbor, MD

N Mishra, J McDevitt, G DeNoto, G Gecelter, **E Rubach.** Single-incision laparoscopic cholecystectomy in modified lithotomy position – improved ergonomics for surgeons and surgical assistants
SAGES 2010Scientific Session National Harbor, MD

N Mishra, J McDevitt, G DeNoto, G Gecelter, **E Rubach.** Gallbladder retraction without transcutaneous sutures during single-incision laparoscopic cholecystectomy
SAGES 2010Scientific Session National Harbor, MD

N Mishra, V Kamath, V Gunabushanam, K Krishnasastry, **E Rubach.** Laparoscopic Left Gastric Artery Aneurysm Resection
Southeastern Surgical Congress 2010 Meeting Savannah, GA

D Eschete, N Mishra, M Ostrowitz, H Zemon, **E Rubach**, G Gecelter, G DeNoto. Single-incision Laparoscopic Cholecystecto-my: Short-term Outcomes
SAGES 2009Scientific Session Phoenix, AZ

E Rubach, G DeNoto. Single-incision Laparoscopic Surgery Using Flexible-tip Laparoscope
American College of Surgeons 2008 San Francisco, CA

G Gecelter, D Shin, C Seideman, G DeNoto, **E Rubach**, M Sette, et al. Eye Tracking As A Tool To Measure Laparoscopic Skills

SAGES 2008 Scientific Session Philadelphia, PA

G Gecelter, D Shin, **E Rubach**, J Klein, G DeNoto. A Novel Method of Mesh Placement in Laparoscopic Repair of Giant Paraesophageal Hernias.
SAGES 2008 Scientific Session Philadelphia, PA

A Joshi, **E Rubach**, G Gecelter. A Technique For Laparoscopic Feeding Jejunostomy Using A Balloon-Tip Catheter
SAGES 2007 Scientific Session Las Vegas, NV

R Zaidi, **E Rubach**, G DeNoto. Laparoscopic Hartmann's Procedure: A Viable Option In Treating Acutely Perforated Diverticultis
SAGES 2007 Scientific Session Las Vegas, NV

A Joshi, J Spivak, **E Rubach**, G DeNoto. Totally Robotic Transabdominal Preperitoneal Inguinal Hernia Repair During Robotic Prostatectomy
Minimally Invasive Robotic Association (MIRA) 2007 Scientific Session New York, NY

E Rubach, G Gecelter. Hepp-Couinaud Hepatico-Jejunostomy Using a Novel Suture Organizer.
American College of Surgeons 2005 Scientific Session San Francisco, CA

G DeNoto, **E Rubach**, G Gecelter. Totally Robotic Minimally Invasive Sigmoid Colectomy.
American College of Surgeons 2005 Scientific Session San Francisco, CA

E Rubach, A Isenberg, T Singh, D Conti. Laparoscopic vs. Open Donor Nephrectomy: Comparison of Outcomes.
SAGES 2005 Scientific Session Ft. Lauderdale, FL

E Rubach, G Gecelter. Outcomes of Laparoscopic Heller Myotomy with Angle of His Reconstruction.
XXX National Congress of Colombian Association of Surgeons 2004 Bogotá, Colombia

OTHER RESEARCH EXPERIENCE

2008-2014	St. Francis Hospital *Outcomes of Laparoscopic Repair of Hiatal Hernias with mesh*	Roslyn, NY
2004	North Shore/Long Island Jewish Health System *Achalasia And Gastroesophageal Reflux Disease: Outcomes Of Laparoscopic Heller Myotomy With Angle Of His Reconstruction*	Manhasset, NY
2003	Institute of Minimally Invasive Surgery *Laparoscopic Nephrectomy for Transplantation: Donor and Recipient Outcomes*	Albany, *NY*
2002	Institute of Minimally Invasive Surgery *Laparoscopic Nissen Fundoplication and Changes in Pulmonary Function in Adult Patients with Cystic Fibrosis*	Albany, NY
2002	Institute for Vascular Health and Disease *Utility of Continuous Wave Flow Doppler in Evaluation of DVT*	Albany, NY

1996 University of Medicine and Dentistry of NJ Newark, NJ
Presence of Defensins in the GI tract of Mice

ADMINISTRATIVE RESPONSIBILITIES

2018-current St. Francis Hospital Roslyn, NY
Hospital Medical Executive Committee member

2016-current St. Francis Hospital Roslyn, NY
Glycemic Control Committee member

2013-current St. Francis Hospital Roslyn, NY
American Cancer Society Physician Liaison

2009-current St. Francis Hospital Roslyn, NY
Surgical ICU Quality Improvement Committee Member

2009 SAGES Phoenix, AZ
Faculty, Moderator of Plenary Session

2007-2010 SAGES Los Angeles, CA
Flexible Endoscopy Committee Member

2007-2008 North Shore LIJ Healthcare System Manhasset, NY
Physician Quality Reporting Initiative (PQRI) Committee Member

2003-2004 Albany Medical Center Albany, NY
Information Technology Committee Member

INDUSTRY RELATIONSHIPS

2008-current Covidien, Inc. New Haven, CT
Consultant
Trainer Surgeon for Clinical Immersion Hernia Programs

2012-2014 Ethicon, Inc. Somerville, NJ
Consultant for Hernia and Suture Development Program

2008-2010 W. L. Gore & Associates, Inc. Newark, DE
Course Faculty

VOLUNTEER EXPERIENCE

2014-2019 Mercy Ships – Africa Mercy Benin, Madagascar, Cameroon, Guinea
Staff General Surgeon during missions in Africa

2005-2009 North Shore LIJ Health System Charity Clinics Manhasset, NY
Staff General Surgeon

1995-1999 Callmen's Emergency Unit Union, NJ
Volunteer member of the ambulance squad

LANGUAGES

Russian, Ukrainian

INTERESTS AND ACTIVITIES

Computers, art museums, photography, Formula 1, travel

APPENDIX B

APPENDIX B

Pleadings and Legal Correspondence

In re: da Vinci Surgical Robot Antitrust Litigation, U.S.D.C. (N.D. Cal.), Case No. 3:21-cv-03825-VC, Consolidated Amended Class Action Complaint, September 10, 2021

Depositions

Rebotix Repair, LLC v. Intuitive Surgical, Inc., U.S.D.C. (M.D. Fla.), Case No. 8:20-cv-02274

- Deposition and Exhibits of Dr. John Bomalaski, October 8, 2021
- Deposition and Exhibits of Myriam Curet-McAdams, M.D., May 7, 2021

Restore Robotics LLC and Restore Robotics Repairs LLC v. Intuitive Surgical, Inc., U.S.D.C. (N.D. Fla.), Case No. 5:19-cv-55-TKW-MJF

- Deposition and Exhibits of Eugene Otto Dickens, M.D., May 27, 2021
- Deposition and Exhibits of Myriam Curet-McAdams, M.D., May 7, 2021

In re: da Vinci Surgical Robot Antitrust Litigation, U.S.D.C. (N.D. Cal.), Case No. 3:21-cv-03825-VC

- Deposition and Exhibits of Dr. Greta Bernier, November 7, 2022
- Deposition and Exhibits of Ricardo Estape, M.D., October 22, 2022
- Deposition and Exhibits of Michael Burke, M.D., September 27, 2022
- Deposition and Exhibits of John Francis, M.D., October 14, 2022

Other Expert Reports

Rebotix Repair, LLC v. Intuitive Surgical, Inc., U.S.D.C. (M.D. Fla.), Case No. 8:20-cv-02274:

- Expert Report of Dr. John Bomalaski, July 26, 2021

Bates-Stamped Materials

Intuitive-00645431
Intuitive-00002201
Intuitive-00002502
Rebotix068404
Rebotix060986
Rebotix175327
Rebotix060993
Rebotix060990
Rebotix162404

Third Party Materials

Academic Literature

- J Laparoendosc Adv Surg Tech A. 2006 Dec;16(6):551-6. doi: 10.1089/lap.2006.16.551
- Surg Endosc. 2012 Oct;26(10):2711-6. doi: 10.1007/s00464-012-2478-y. Epub 2012 Aug 31
- Surg Endosc. 2012 Apr;26(4):956-63. doi: 10.1007/s00464-011-1977-6. Epub 2011 Nov 2